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CONTENTS.

CLINICS.

CLINICAL LECTURES.

Notes of a Clinical Lecture on some points in the History of Pneumonia, especially its Duration	129
Notes of a Clinical Lecture on Acne	132
Treatment of Phthirical Cavities	135

HOSPITAL NOTES AND GLEANINGS.

Hospital Notes. King's College Hospital: Dr. Johnson's Wards	136
Lymphadenoma of the Pelvis; Hematuria; Transfusion; Death three days subsequently	139

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CLINICS.

CLINICAL LECTURES.

Notes of a Clinical Lecture on some points in the History of Pneumonia, especially its Duration. Delivered at St. Bartholomew's Hospital. By JAMES ANDREW, M. D., Physician to, and Joint Lecturer on the Principles and Practice of Physic at St. Bartholomew's Hospital.

Gentlemen: I shall not attempt to-day to give you a systematic account of pneumonia or a description of the physical signs. I shall be content to give little more than illustrations of the clinical history of the disease which have recently come under our notice here, and thus help you in some of the difficulties which beset students.

MEDICAL NEWS.

Original Article—Death from Gunshot Wound after an interval of Fourteen Years	141
Domestic Intelligence—Canada Medical Association	141
American Public Health Association	141
Minnesota State Medical Society	141
Illinois State Board of Health	142
Bromide of Ammonium in Hay Fever	142
Honor to the Physicians of Pittsburg	142
Obituary Record	142
Foreign Intelligence—Slow Pulse	142
Hay Fever	142
Fetid Feet	142
Death from Milk in the Trachea	143
Deaths from Chloroform	143
Colour-blindness among Railroad Employees	143
Dr. Lewis A. Sayre in London	143
Dr. Edward Warren	143

1st. What is pneumonia? Let me tell you what it is not. It is not simply consolidation of the lung tissue. Thus in a patient with heart disease or pyæmia, the physical signs of consolidation of more or less lung tissue are developed; but you have no right whatever to say that he has got pneumonia. Pulmonary consolidation by itself no more proves the existence of pneumonia than a tumour does that of cancer, delirium that of inflammation of the brain, or a high temperature that of typhus fever. Like all other diseases, pneumonia is constituted not by any single symptom, but by the sequence and relation in which certain symptoms occur. It is outside my purpose here to attempt to define pneumonia. You may lay stress upon the febrile movement or

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VOL. XXXV.—9

the local change, but the essentials of the disease are acute invasion, the invasion being marked by the prominence of certain symptoms, especially rigors and frontal headache, and soon followed by the local signs of pulmonary consolidation. In this respect it differs from pleurisy, in which the local symptoms very commonly precede the general ones. After the febrile movement has lasted from five to eight days—seven days is the most usual period—rapid and complete defervescence takes place, followed by a more leisurely restoration of the lung to a healthy state. Remember, of the two different classes of symptoms, local and constitutional, one is just as necessary as the other. Lung consolidated without a certain type of fever has no more right to be called pneumonia than fever without consolidation. In fact of the two the latter would be nearer the truth. You may be now and then fully justified in making a diagnosis of pneumonia, although none but the slightest, perhaps even no physical signs may be present. In the same way you know that the so-called eruptive fevers, even smallpox, are not always attended by the eruption.

Take the following cases as illustrations of typical pneumonia, especially in respect to its duration.

George B., *æt.* 9, admitted April 12th; consolidation of left lower lobe, with great pain, which was relieved by one or two leeches. Illness began on April 7th. On April 12th the evening temperature was 102°. On the morning of April 13th, *i.e.*, on the seventh day of the disease, it had fallen to 98°.

Joseph R., *æt.* 8, admitted on May 5th, with a temperature of 108°.5. On May 6th, in the afternoon, it was still 102°.2; at midnight it was 98°.6. He had been taken ill on April 30th, therefore defervescence occurred on the seventh day.

Patrick M., *æt.* 13, admitted May 18th, with a temperature of 101°.6. This comparatively low temperature was probably due to the cooling effect of his removal to the hospital, for on the same evening it rose to 108°, and he became delirious. On May 19th, his temperature fell to 96°.4. His illness had begun on May 14th,

and had thus lasted six days; the left lower lobe was the part affected.

John R., *æt.* 5, pneumonia of the left lower lobe. Taken ill on May 18th, admitted on May 21st, with a temperature of 103°. The fever subsided suddenly on May 28th, the eleventh day of the disease.

Remember, I am only giving you illustrative cases, not attempting to prove an already well-established fact by statistics; and please notice that in all the defervescence was final, followed by rapid and complete convalescence, whilst the youth of the patients and the probable soundness of their organs at such an early age justify us in supposing that we have here instances of the simple, uncomplicated type of pneumonia.

Unfortunately, we know too well that pneumonia does not always run this favourable course, that defervescence may be deferred indefinitely, and that it often ends fatally. What are the conditions which interfere with the favourable history of the disease? Remember again, if you please, that I am giving only illustrations, not statistical proofs.

Charles H., *æt.* 49, pneumonia, right apex; subject to cough for some years, but never spat blood; admitted on April 21st, his illness having begun some six weeks previously. Up to April 28th his temperature was about 101°, on that day it became normal and remained so, but on May 23d, notwithstanding progressive improvement in the physical signs and general condition, there were still at the right apex some impairment of resonance, coarse respiratory murmur, and occasional crepitation.

John N., *æt.* 31, a drunkard, died three days after admission with consolidation of the right upper lobe. At the autopsy, the lung was found in part gangrenous, but there were no traces of chronic disease.

These two cases illustrate the danger of apex pneumonia, and also, perhaps, the causes of the gravity of this form of the disease.

The apex is the favourite seat of chronic changes more or less serious, and thus great additional embarrassment is caused by the occurrence of acute consolidation;

and next, the apex is probably more liable than the base to the serious forms of acute as well as of chronic disease. But you must not suppose that the apex pneumonia is always of abnormal type. We had, not long since, in Mark ward, a case in which defervescence took place on the seventh day. The first condition, then, which I have to mention as interfering with the natural course of the disease, and prolonging or rendering it especially serious, is the occurrence of consolidation at the apex.

Next, remember that the prognosis as to the duration of the disease is always unfavourable if there be much pleuritic effusion in its earlier stages. True, pleurisy is almost always present, but I am speaking now not of mere inflammation of the visceral layer of the pleura over the consolidated portion of lung—often, by the way, the cause of severe pain—but of effusion into the pleural cavity; of cases, that is, in which you find the physical signs of fluid as well as of solid lung. Of this class of cases we have lately had several in the hospital. I shall content myself by just mentioning two. In one death took place after three months' illness; in the other, imperfect defervescence at the end of three weeks was followed slowly by protracted convalescence. In these cases the febrile movement is kept up, not by the pneumonia, but by the pleurisy, *i.e.*, by the spread of the inflammation, set up at first by a specific cause, to neighbouring tissues, just in the same way that ulceration in the intestines in typhoid fever, and in the neck in scarlet fever, spreads to the cellular and other tissues contiguous to the glands at first affected.

Again, the violence of the pneumonic inflammation may completely destroy the vitality of the parts affected. Generally this proves fatal, as in one of the cases already mentioned; sometimes, if the patient survives, it leads to the rapid formation of a large cavity. There is a case of this kind at present in the Mark ward. The patient, a man, *æt.* 26, who has suffered from no previous illness, will tell you almost the exact spot in a court out of Fleet-street where, whilst coming from

his work, he was attacked some eight weeks ago by violent rigors and frontal headache, soon followed by cough. On admission, some six weeks afterwards, he had the physical signs of the lung breaking down at the right apex, and soon there were the usual signs of a cavity, among others, the so-called cracked pot sound. For some little time the cavity increased almost daily in size; it is now contracting. The moist sounds are disappearing, and his general condition rapidly improving. At the same time, however, the heart is becoming gradually displaced to the right. These cases are much more common, at least in my experience, in children than in adults, and often lead to great displacement of the heart. It may be, however, that it is not the form of disease but the recovery which is more common in childhood.

I tell you that pneumonia is an acute specific disease, or, at any rate, that it deserves the name as much as scarlet fever, typhus, erysipelas, or smallpox; and further, that it most distinctly belongs to the class of diseases which have a definite duration; the termination of a pneumonia can be predicted as successfully as that of typhus fever. But you must not suppose that there are no transitional forms, no links between it and other forms of disease. Here are two illustrations of what I have ventured to call transitional forms. A girl, *æt.* 18, was admitted about twelve months ago into Mary ward with pleuro-pneumonia of the left side, pericarditis and albuminuria, and we never succeeded in ascertaining which of the local diseases began first. Again, only last week I saw a hardworked clergyman who two years ago, under close and highly-skilled observation, had consolidation of the right lung and albuminuria, apparently beginning simultaneously with the usual symptoms of pneumonic fever. Now in these cases I hold, with Dr. Basham, that the pulmonary consolidation and the nephritis are co-ordinate effects of one general change. But this does not hold good absolutely in cases such as the following. A man, *æt.* 23, was admitted about six months ago under my care with pneumo-

nic fever and consolidation of the lower part of both lungs, but he had previously had scarlet fever, followed by dropsy, and the pneumonia began with its usual symptoms during the dropsy.

Again, consolidation of the lung, attended by increase of febrile movements, frequently occurs in connection with rheumatic, typhus, and typhoid fever, and from these it is but an easy step to the same event in pyæmia and heart disease. Now in these two latter cases we have seldom, if ever, the right to use the term pneumonia, and yet it is difficult to say at what precise point in the series it ceases to be applicable.

Let me say just a word or two as to some of the causes of pneumonia, and with special reference to its specific character. First, it is a disease of the spring and early summer months; it may be that this is due to the greater liability to chills which the increased day heat brings with it, or that there is some more general atmospheric condition which predisposes to it.

Next some cases of pneumonia are most certainly pythogenic in origin. I have myself seen two remarkable series of cases in which it was impossible to doubt that defective sewage was the cause; and during this present spring a friend of mine at Dorking has met also with a series of six or seven cases depending upon the same apparent cause. Sometimes mere irritating vapours develop constitutional and local disturbance, closely simulating pneumonia. Thus I have had under my care a patient who, after exposure to the vapour of strong liquor ammoniac, had consolidation of one lung, with marked febrile movement.

We have no time to-day for any detailed discussion of the treatment of pneumonia. I wish to impress two things only upon you. Don't over-treat your patient—you can no more cure the disease than you can cure typhus fever or smallpox; he will get well when the disease reaches its period if your over-activity does not prevent it. And lastly, do not over-examine your patient—the harm done by frequent elaborate examinations will most certainly overbalance any good you or he

will derive from them.—*Med. Examiner*, July 12, 1877.

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Notes of a Clinical Lecture on Acne.
By JONATHAN HUTCHINSON, F.R.C.S.—
When the face is covered with pimples, some of which are red, some contain pus, and others show only black points in their centres—all kinds being present, and all slow in progress—it is commonly agreed to call the condition Acne. If the spots are angry and suppurate quickly, it is acne pustulosa; if they are small, very florid, and not prone to suppurate, it is acne rosacea; if there is great thickening about them, and again little tendency to suppurate, it is acne tuberculata; if there are numerous black points to be seen, it is acne punctata; lastly, if no one of these features be in excess of the others, it is common acne—acne vulgaris. Now, let us first understand clearly that these various adjectives do not denote different diseases, but merely different conditions of the same disease, which may be frequently met with in one and the same case. Next, we will observe that all forms of acne are inflammations of sebaceous follicles. I have already said that, when a follicle inflames, three results ensue—a thickening of its gland tissue, deposit and congestion of the cellular tissue around it, and accumulation of its secretion in its interior. Now, we have in acne all shades of variety as to these three results. Every one is familiar with the little black dots so frequent in the skin of the face of those who have rather coarse complexions. In degree they may perhaps be found in the skins of most persons, especially about the nose. If you squeeze them, little black-headed "maggots" are ejected. These maggots, or grubs, are not living, but consist of half-dried sebaceous matter, which had accumulated in the cavity of the gland, and which has been moulded into the pellet form in passing through the constricted opening. The black head is the end of the pellet, which, having been long exposed at the mouth of the duct, has gathered soot.

It is not always that the end of the pellet gets blackened; sometimes, and espe-

dially in young persons, the mouth of the follicle is closed by a delicate membrane, and then the secretion collected beneath it is seen under its transparent covering, and remains quite white. In infants this distension of closed follicles constitutes what used to be known as *strophulus albidus*; in adults it is more frequently seen on the eyelids than on other parts.

Sometimes the interior of the follicle suppurates, and, after removal of the pellet, pus escapes. This constitutes pustular acne.¹

It is a peculiar feature of the condition known as acne, that at one and the same time, in the same patient, you will find the follicles in all stages of disease, some simply distended and free from material irritation, others congested also, others suppurating. In this it differs much from lichen.

Acne is emphatically a disease of coarse skins; or rather, perhaps, we ought to say that the term "coarse skin" usually applies to integument in which the sebaceous follicles are larger than ordinary, and have gaping mouths. This causes the skin to look rough and pitted. It is a state of skin the tendency to which is often hereditary, and it is thus often seen in several members of the same family.

Acne spots cause more annoyance on the face than elsewhere, and hence an exaggerated impression as to their great relative frequency on this part. Although there is no doubt that the face and shoulders are their usual sites, yet, if you will examine the general surface of acne patients, you will very frequently find the spots, in smaller numbers, on the trunk and the upper arms also.

Having asserted that all persons of coarse skin are liable to have their sebaceous follicles take on occasionally the acne inflammation, we may suitably ask what are the causes which induce the more severe forms of the disease. For clinical purposes we may recognize acne chiefly in two forms—first, the acne of young persons; and second, the acne of those past middle life. It is in young persons that we meet chiefly with the

pustular, punctate, and vulgaris types, whilst in the elderly we encounter the acne rosacea and tuberculata. Respecting the acne of the young, there is a very widespread opinion that it is usually the result of sexual disturbance. I have no doubt that this belief is well founded to some extent, but we must beware of exaggerating it. The eruption is chiefly met with in young celibates, whilst it is very rare under the age of puberty, and is often benefited by marriage. It is possible, however, that its comparative rarity in the married may after all be a coincidence and not a sequence, and that we ought to consider it not so much a disease peculiar to celibacy as to the special age at which a large majority of the population are celibates. It may certainly occur before puberty. I have seen it not very infrequently in children, and once in a very marked form in the face of an infant of six months. It is also frequent in married persons of both sexes, and sometimes originates after marriage. I have known it occur in ladies who were bearing children, and in whom the sexual functions appeared to be in perfect activity.

Making full allowance for a considerable number of acne cases in which there appears to be no sexual cause, there are yet, I think, good grounds for accepting the general belief that in a majority of instances such is the fact. The remarkable influence which the sexual functions exercise upon the general health and upon the state of the nervous system is amongst the secrets known unto all men. That they should have the power of making the sebaceous glands of the skin enlarge and suppurate is certainly, if thought about, one of the most strange. I suspect that, when it occurs, it is brought about through the agency of the nervous system rather than of the blood. Women who are not liable to acne at other times sometimes have a few spots appear at each menstrual period, and that whilst in excellent general health. I have been assured by gentlemen liable to nocturnal emissions that they invariably had an increase of acne spots after such occurrences, and sometimes so im-

¹ By some authors called *Milium seu Gratum*.

mediately, that it was impossible to believe that any material change in the blood had occurred. In other cases sexual intercourse may produce the same result.

It is certainly not in cases of extreme sexual exhaustion that acne is most common. I have seen many such patients, both with and without spermatorrhoea, who had not a spot of acne, but, on the contrary, had skins which were perfectly smooth—in some instances florid, in others earthy pale. It is, perhaps, rather a condition of sexual irritability than of exhaustion which produces acne. I do not think that the severity of the acne eruption bears any relation to the degree of sexual disturbance. In the worst cases that I have seen the patients often seemed to be in good health.

To dismiss the subject, we may remark that the prescriber ought, in respect to the acne of celibates, to bear in mind the possibility of a sexual cause. He will advise the adoption of measures likely to improve the general vigour, he will caution against any possible causes of debility, and he may, in some instances, suggest matrimony as the remedy most likely to prove successful. Derangements of stomach and liver stand in about the same relation to the acne of middle-aged persons that sexual causes do to the acne of early life. Manifest dyspepsia (often the result of intemperance) is present in perhaps half the cases of acne rosacea, whilst in the other half it is exceedingly difficult to assign any cause. The same remark applies also to the indurated and tuberculous form of acne, which produces the thickened, bossy condition of skin familiarly known as "grog-blossoms," and usually considered to be proof of intemperance. In many cases such suspicion is most unjust. At any rate, of this you may be sure—that in persons congenitally of coarse skin very slight indulgence at the table may produce results in the way of acne, which would not ensue in others whatever the amount of provocation afforded. As I asserted in reference to sexual exhaustion, so I may say here again, it is common enough to see the most intemperate escape scot-free. No-

thing would be more unjust than to allow ourselves to entertain the belief in the one form of acne, that it is certainly due to sexual causes, or in the other that intemperance or gluttony is the cause. We will freely admit a frequent connection, but strongly deny that it is invariable. For the worst forms of acne of either variety you will be able to discover in the patient's state of health or antecedents no cause whatever, and you will be compelled, in considering your measures of treatment, to regard it chiefly as a local disease.

The rules for the constitutional treatment of acne patients follow easily from what we have said. If the patient be young he should be made to use a cold bath every morning, to take plenty of exercise, to live liberally as regards meat diet, with a fair allowance of stimulants; and he should be cautioned or encouraged, as the case may be, in reference to sexual matters. As to medicines, a long course of small doses of arsenic will often be of great use. If constipation be present, the habitual use of a chalybeate aperient should be prescribed. You may do all this, however, most sedulously, and gain nothing whatever, if you neglect local measures; whilst with the latter only, and without any change in the patient's habits, you may often get an acne eruption so nearly well that he will regard it gratefully as a cure. The chief local measure consists in destroying, by means of a fluid caustic, the inflamed follicles. With a fine-pointed glass brush, or a bit of soft wood cut to a point, you touch the inflamed spots from day to day. Take great care not to apply too much. In the left hand should be a roll of blotting-paper with which to absorb the fluid if it has been deposited too abundantly. The best fluid to use is the acid nitrate of mercury. It will usually be necessary to repeat the touching once a week for a month or two, carefully seeking out every fresh spot. After that the patient should still see you once a month, in order that the cure may be kept up. The acid thus used does not leave larger scars than the spots would themselves do.

In acne rosacea the use of the caustic

will again serve an excellent purpose. You may not only touch the spots themselves, but also pencil out the stray vessels which add so much to the patient's disfigurement. He, or more usually she, will gladly exchange a few slight and scarcely perceptible scars for the angry and very suspicious-looking redness of face which the disease causes. — *Med. Times and Gaz.*, July 28, 1877.

Treatment of Phthisical Cavities.—In the course of a clinical lecture on Excavation of the Lung in Phthisis (*Lancet*, August 4, 1877), Dr. R. DOUGLAS POWELL, Physician at the Brompton Hospital for Consumption, said: I purposely avoided saying anything about the treatment of contracting cavities, for I believe that there is nothing special to say about them. There is one point, however, as regards the management of cough in these cases that may be mentioned. It often happens that the patients, long accustomed to expectorate easily, complain of "tightness" of the chest, and dry, teasing cough. This cough must of necessity be allayed by the free use of cough mixture, but the patients should at the same time be directed to restrain, as far as possible, by an effort of the will, the cough, which by its rending action tends to disturb the healing process going on in and around the cavity. We must do what we can to keep the patient in his favourable condition of general health; we must watch for, and by timely treatment subdue, catarrhs, or, still better, if possible avoid them by judiciously-selected climates. We can give no medicine that will directly hasten the contraction of cavities. In some cases we may try by the selection of high climates to encourage the more rapid expansion of the opposite lung.

In the treatment of secreting cavities, the objects we have in view are (1) to lessen secretion, (2) to promote evacuation of what secretion is formed, and (3) to disinfect such cavities. Counter-irritation—of little use, I believe, whilst cavities are still forming or extending—is of great service in these cases. When we remember that in chronic excavation of

the lung we almost invariably get an intimate union of the two pleural surfaces and an anastomosis of their vessels, we may see why the application of a blister externally may affect such cavities. As a matter of fact, they do influence them most decidedly. Strong iodine applications (two drachms to the ounce), or flying blisters, or perhaps a blister kept open for a few days by the use of savin ointment dressing, are the forms of counter-irritation suitable to different cases. Under their use the cough and expectoration frequently diminish. Acids and astringent iron tonics and oil are needed. Sedative cough mixtures are directly contra-indicated in these cases, except for the purpose of giving rest at bedtime. It is in these cases that inhalations are most useful; for, firstly, there being no actively spreading disease present, they can do no harm; secondly, we can by their use render less noxious the pus that bathes the surface of the cavity, and which is apt to become inhaled during the effort of expectoration into distant parts of the lung; thirdly, inhalations help expectoration; fourthly, there can be little doubt that appropriate inhalations sometimes have a healing or an alternative effect upon the internal surface of the cavity.

The best substances for inhalation are—iodine (vapor *iodi* B. P.), only to be used occasionally and for a few days together; carbolic acid (glycerine of carbolic acid, one drachm to two drachms, to half a pint of hot water); or tar water (liq. carbonis detergens, one drachm, to half a pint of hot water); useful disinfecting and, except iodine, somewhat sedative inhalations, that may be employed two or three times a day. They may be taken very well from a deep jug or a Nelson's inhaler with the sponge removed. Friar's balsam, tincture of larch, turpentine, etc., may be similarly employed from time to time. Perchloride of iron or other astringents may sometimes be used with Siegle's spray apparatus; but I have myself failed to find atomized astringents useful in these cases, and doubt if they penetrate so far as vapours inhaled in the ordinary way. Sea air, and perhaps especially sea-shore

air, containing more or less salt spray, is usually beneficial to these patients. A liberal diet is of course necessary.

Cases of active or ulcerous cavities may require at first the free administration of alcoholic stimulants; a somewhat liberal allowance of wine is also subsequently needed, with nutritious support and abundance of good air. These active or ulcerous cavities tend to become endemic in over-crowded wards, and their occurrence should always lead us to look to sanitary arrangements, for their pathology strongly suggests their erysipelatous nature. It cannot, indeed, be too carefully remembered, in the treatment of patients with phthisical affections of the lungs, that they have internal wounds or sores, which, unlike most other internal affections, are accessible to the contamination of foul air, and that thus erysipelatous processes may be readily set up which are too apt to be recognized only as "intercurrent pneumonias" or other local inflammations.

Medicinally these cases may be combated by quinine internally, or in some cases full doses of perchloride of iron; sedative inhalations, containing tincture of benzoin and opium, hyoscyamus and chloric ether, carbolic acid and opium, etc., are useful. Ipecacuanha wine, administered as spray with Siegle's inhaler, is worth a trial, but patients suffering from this condition of cavities are often too prostrated to bear the fatigue of inhaling. If the more active general symptoms should lessen, but a blood-stained and copious expectoration still leads us to infer that the walls of the cavity are hyperemic, I am convinced from observation that the best treatment is to apply a blister over the region of excavation, and to keep it freely discharging for several days by means of savin ointment dressing. I have seen the active symptoms completely subside under this treatment—which is, however, somewhat severe and painful—and the cavity subsequently contract, the expectoration, from being abundant and sanguineous, becoming scanty, viscid, and apparently consisting of bronchial mucus only.

Attempts have been made from time to time to treat lung cavities, on surgical

principles, as local abscesses, by evacuation of the matter from without, or by the injection of astringent or disinfecting solutions. Dr. Mosler, in the *Berliner Klinische Wochenschrift* for October, 1878, relates three cases which he has treated in this way. In the first two cases he introduced a small canula into the cavity, and daily injected a small quantity (twenty cubic centimetres) of permanganate of potash solution without causing any serious inconvenience. In a third case he introduced a silver drainage-tube into a large cavity, through which much discharge escaped. After six weeks the patient had slight hæmoptysis, and a weak solution of perchloride of iron was injected, and subsequently a pulverized weak solution of carbolic acid and iodine were blown through the canula. The patient died at the end of three months of amyloid disease of organs.

Dr. Wm. Pepper, of Philadelphia, has treated three cases by the injection of astringents through a fine Dieulafoy's needle, in one case, he states, with positive improvement. He suggests that hæmoptysis should be treated in this way.

These procedures, and others of a like kind, can only as yet be regarded as tentative, and as useful in showing what can be done if necessary in cases of the kind. So far as we can see at present, however, cases must be extremely rare in which such treatment would be likely to prove useful. It sometimes happens, however, that a cavity is situated quite at the base of the lung, and the removal of secretion from it is extremely difficult, attended with vomiting and great distress; portions of the irritating matters from the cavity are inhaled into the bronchial tubes of the other lung, setting up fresh inflammatory centres there. In these cases the cavity, being at the lowest point of the lung, might well be treated as if it were a pleural abscess.

HOSPITAL NOTES AND GLEANINGS.

Hospital Notes. King's College Hospital: Dr. Johnson's Wards.

Stricture of the Oesophagus.—A woman, forty years of age, and markedly ema-

ciated, complained of great difficulty in swallowing. Her illness commenced four months previously to admission, with difficulty in deglutition, which had gradually increased, and during the last three weeks she had become rapidly worse, so that she was able to swallow nothing but a little milk and beef-tea, and had suffered much from hunger. An oesophageal bougie, when passed, met an obstruction opposite the thyroid cartilage, and could not be passed further. There was no difficulty in respiration, and the lungs and heart presented no signs of disease. On laryngoscopic examination, a white mass was seen situated between the larynx and pharynx. She frequently complained of pain towards the left side of the larynx. As the stomach-tube could not be passed, a No. 10 elastic catheter was used, and this easily slipped past the obstruction. The stomach-pump was then attached to the catheter by means of a piece of elastic tubing; and strong beef-tea, eggs, and milk, etc., were injected. This method of feeding has been repeated at intervals, and has been followed by a considerable amelioration of the patient's condition.

Dr. Ferrier: Out-Patient Department. Hemichorea.—A woman, twenty-three years of age, complained of a troublesome jerking of the right arm, often, she said, as violent "as if it would tear out the arm from its socket." This illness followed her confinement six weeks ago; she had never had chorea previously, but seven or eight years ago she was attacked with "rheumatics," which, however, did not prevent her moving about. A sister, aged twenty-eight years, had, while pregnant, been attacked with a fit, followed by general and violent chorea; there had also been considerable mental disturbance after her confinement, necessitating her removal to an infirmary. The patient was much distressed and frightened by her sister's illness; and three days after her own confinement, which was long and trying, choreic movements commenced in her left arm and leg; these have been accompanied by burning sensations in the left side of the body and in the back. Muscular power was much diminished in the left hand, but there was no anaesthesia.

When the woman held out her arms, constant irregular movements were seen in the left arm and hand; so also with the left foot and leg when the patient sat down and held out both feet. The left side of the face twitched somewhat, and, when standing erect, the body swayed from side to side. There were no signs of heart-disease. Dr. Ferrier considers that the pathology of chorea has yet to be made out, and is not much inclined to give credit to the theory of embolism or thrombosis. In the course of Dr. Ferrier's physiological experiments, a monkey, in whom the lateral portions of the cerebral hemisphere were exposed, became choreic on the opposite side of the body, and subsequently developed epileptic convulsions. The symptoms of chorea differ from those of sclerosis in being more constant and irregular, not simply coming into prominence when a voluntary effort is made, as in sclerosis. In paralysis agitans, again, the movements may be described as constant and vibratory in character. The patient was ordered liquor arsenicalis.

Cutaneous Hemianæsthesia.—A woman of nervous manner complained of numbness of the left side of the body, arm, and leg; also of "flushing heats." When her eyes were shut, on touching with a needle the corresponding points on the two hands, she said she did not feel the touch on the left side; but if the needle perforated the skin, she could feel the prick. Similar anaesthesia was found in a less marked degree on the left side of the face. Sight was equally good on both sides. Hearing, as tested by the watch, was fair on both sides, rather more acute in the right ear. A vibrating tuning-fork, placed on the bridge of the nose while the woman closed her ears, was longest audible in the right ear. The sensibility of the tongue, both to touch and taste, was diminished on the left side. Smell was tested by holding tincture of assafoetida to each nostril alternately, the eyes being closed; the patient seemed hardly to perceive it at the left nostril. Taste and tactile sense appeared to be diminished on the left side of the tongue. The woman was also liable to attacks of headache, with dysæsthetic

ocular phenomena, described as "wheels of brightness." She suffered from dysmenorrhœa and slight menorrhagia; no abnormal condition of the uterus was found, but there was marked tenderness in the left ovarian region. As usual in cases of neurosis dependent upon ovarian irritation, there was tenderness over the fourth dorsal vertebra. Dr. Ferrier expressed his belief that many cases of hemianesthesia would be found if they were more frequently looked for. In this class of cases, hystero-epilepsy (Charcot) is frequently met with, and such attacks may often be arrested by firm pressure over the ovary affected.

Cross Paralysis.—A woman, aged 32, was attacked last January with a fit, accompanied with loss of consciousness; the face was drawn to the left side, and the left arm and leg were paralyzed both as to motor power and sensibility; she also lost the power of speech for a week. When examined, on making her show her teeth and by watching the features while she was speaking, it was evident that the *right side of the face* was partially paralyzed, especially in its lower parts, while the left arm and leg were much weaker than the right. This condition of hemiplegia on one side, with paresis of the face on the other side, both having occurred at the same time, indicated a probable lesion in or near the pons Varolii.

Facial Neuralgia.—A woman, forty-three years of age, of nervous temperament, complained of a sense of oppression at the back of her head and violent facial neuralgia, accompanied with loss of sleep. This appeared to have followed the mental shock and depression due to the illness and death of her mother. She was ordered bromide of potassium.

Fits, with Disease of the Heart.—A woman, aged 40, complained of attacks apparently epileptoid, and attended by partial syncope; consciousness was lost in these fits, and there was struggling; sometimes the tongue was bitten. Examination showed signs of both aortic and mitral regurgitation. There was no family history of neuroses; and cerebral anæmia, due to the defective circulation,

appeared to be an important element in the causation of the attacks. Dr. Ferrier ordered a mixture of digitalis and bromide of potassium, and remarked that while the bromide would lessen the conductivity of the nerve-fibres, as indicated by its action in rendering the mental powers dull, the digitalis would render the nervous centres less excitable to reflex action, and increase the muscular strength of the heart.

Mr. Wood's Wards. Sarcoma of the Lower Jaw.—A man, thirty years of age, was operated on a month ago for the removal of a tumour of the lower jaw. A single semilunar incision was made in the line of the lower jaw, the saw was then applied to the bone behind the lateral incision, and, by reflecting the face upwards, the bone was removed with the tumour. The mass proved to be a mixed form of sarcoma, consisting partly of round cells and partly of spindle cells. The tongue was not involved, and the features were but little disturbed. The man is now convalescent, and there is as yet no sign of return of the disease.

Impermeable Stricture of the Urethra.—A man, the subject of a stricture of long standing, was admitted to the hospital with complete retention of urine. The attempt to pass a catheter was made, but failed. A hot bath was used without relief. To relieve the urgency of the case, a fine aspirator needle was passed into the bladder, above the pubis; 36 ounces of urine were thus drawn off. The smallest size elastic catheter was then passed into the bladder, without the stilette, and tied in. Hot fomentations were then applied, and an aperient draught ordered, to be followed by a sedative draught of morphia.

Strumous Disease of Joints.—A lad presented strumous disease of the wrist-joint, and phthisical changes in one lung. The joint was painted with iodine and placed on a straight splint; the hand was then placed in a sling, ice being at the same time constantly applied by means of an ice-bag hung round the boy's neck.

Salicylate of Quinine, in doses of two to five grains, is being tried by Mr. Wood in

cases of chronic suppuration attended with high temperature; the results have yet to be observed.

Recto-vaginal Fistula.—The woman, in her last confinement, was delivered by forceps, three times applied during labour. No immediate ill results followed, and she convalesced; at the end of a fortnight, however, sloughing occurred. When admitted to hospital, the recto-vaginal septum had almost entirely disappeared; a fistula also opened from the bladder and urethra into the vagina. The edges of the fistula were pared, the adjacent mucous membrane was dissected up, a median flap was drawn over the opening, while lateral flaps were united over this by means of wire sutures. There has been no sloughing, and the patient is doing well. Great attention has been paid to cleanliness, and the patient has been kept in the prone position, in order that the urine in the bladder may be prevented from finding its way through the fistula.

Amputation of the Foot; Quick Recovery.—Mr. Wood amputated a boy's foot for disease of the ankle-joint. Dry dressings were applied; union occurred by the first intention, and he was discharged within three weeks of the operation; in another fortnight he was walking about. No special antiseptic method was employed, but great attention was paid to cleanliness.—*British Med. Journ.*, Aug. 4, 1877.

Lymphadenoma of the Pelvis; Hæmaturia; Transfusion; Death three days subsequently.—E. T. C., aged twelve, was admitted into Albert Ward, St. Thomas's Hospital, under the care of Mr. SYDNEY JONES, on April 16, 1877. He stated that he was quite well until one month ago, when he was kicked in the perineum by another boy. He suffered no pain at the time, but two or three days afterwards pain of a dull, heavy character gradually came on, which was worse at night and on sitting down; this interference with sitting was the first thing noticed by the mother. There was no pain on defecation, but the pain kept him awake more or less. The swelling first appeared, about a week after the pain,

as a hard lump the size of a hazel-nut, situated in the middle line behind the anus, but it was never tender at any time; this increased in size until, on admission, it occupied the whole breadth of the perineum, extending from about half an inch in front of the anus to the tip of the coccyx. There was no history of any tumours in the family.

On April 17 the boy was examined by Mr. Sydney Jones, under chloroform. The rectum was surrounded, except in front, by a hard, smooth, new growth. The upper limit could be felt at the extremity of the forefinger as a rounded, defined ridge. The coccyx moved with the tumour. The abdomen was very thin, allowing the spinal column to be felt easily. Ordered twenty drops of the syrup of the iodide of iron twice a day.

May 5. The skin covering the tumour was of a dark-red colour. Complained of much pain in his back. Motions passed involuntarily.

6th. Subconjunctival hemorrhage in right eye.

8th. Rectum again examined under chloroform, and tumour found to have increased considerably in size, having encroached more upon the rectum, so that the finger was very tightly grasped. Upper limit could only be reached with difficulty. An enlarged gland discovered in the right groin, very large and prominent. (A slight trace of this was felt on April 17.) The abdomen was found to be extremely tense, due to a distended bladder. Urine drawn off by catheter. Mr. Jones thought that patient's countenance suggested hemorrhagic diathesis.

11th. On the patient attempting to get up, it was found he could not stand; his legs gave way under him, and he had to be carried back to bed. When in bed he could draw up both his legs, but complained of much pain in the left leg, and also of a feeling of pins-and-needles. On examination, a dark-blue mottled patch (hemorrhagic) was observed on the outer side of the thigh, extending nearly its whole length. Ordered morphia injection. The mother stated that his father is subject to epistaxis.

Although catheterism had been neces-

sary for the last week, on the 14th water was passed freely. A prominence was discovered over the first or second sacral vertebra, and a spot of extravasated blood over it. He complained of feeling unable to move his legs; he could, however, draw them up, but seemed to have lost a great deal of control over them, so that the last part of flexing his thighs was apparently quite passive, the thighs falling helplessly on to the abdomen. The left leg was bandaged from the foot upwards.

15th. Patient looked worse, and extremely anæmic. No further retention; abdomen tympanitic. Motions passed involuntarily up to the 11th inst.; voluntarily since. Gland in right groin no larger; five or six small flat round swellings, about the size of peas, discovered this morning lying under, but not adherent to, the skin of abdomen, also one on left thigh. Some hemorrhage over right tibia, and also a few other spots of hemorrhage in various places. Loss of control over both legs much more marked. Some œdema of scrotum and feet. It was thought desirable to try the effect of transfusion.

16th. Seen by Mr. S. Jones with M. Roussel, the latter performing transfusion at 2 P. M. Cephalic vein opened, and about five ounces of healthy blood injected from the median cephalic vein of Mr. Leatham, one of the students. Before the operation, respiration and pulse were very rapid; during transfusion the boy complained of being unable to breathe, and the cheeks became more rosy. A small pad of oiled lint was placed over the wound, two harelip pins securing the edges. After operation he was removed to bed, wrapped in blankets, and had hot-water bottles applied. 3.20 to 4 P. M. More or less rigors. Complaining of feeling cold; no vomiting. 4.15. Temperature in mouth, 98.4° F. After taking some hot tea and brandy he began to get a little warmer, the colour returning gradually to his lips and cheeks. Involuntary passage of feces; no blood. 4.45. Complained of curious sensations all over, looked frightened, screamed, and tried to throw the bedclothes off, saying he felt so hot. Passed six ounces of urine

deeply coloured with blood, uniformly mixed, after which he appeared easier. Respiration rapid. 5 P. M. Temperature in axilla, 105.4°. Great thirst. 6 P. M. Perspiring profusely; restless and irritable. 7.15 P. M. Much cooler; less quiet and apparently easier; less thirst; lips again blanched. Respiration 48; pulse 108. 8.15 P. M. Has twice passed urine deeply coloured with blood; motions passed voluntarily. 9 P. M. Temperature 100.4°. 11 P. M. Sick for the first time, vomit being of a sour odour, but without bile or blood. Passed a small quantity of urine, bright-red, but less dark than the last three times.

17th. Temperature, 9 A. M., 103.2°. Had two rigors very early this morning. Water passed freely, and each time becoming less red. Took some solid meat for dinner. Complained of headache during the morning; restless and irritable at times. Temperature, 10 P. M., 99.2°. Wound dressed, and looks healthy; some oozing through the bandage.

18th. Temperature 98°, 2 A. M. Slept well, and seems much better altogether. Stronger, but still very anæmic. Vomited twice during the night. Passed water freely without blood, but once had a little discomfort before micturition. Complaints of headache, and no appetite. Temperature 98°, 8 P. M. Ordered five drops of tincture of perchloride of iron every six hours. The bandage on left leg, causing him discomfort, was removed.

19th. Passed a very bad night. About 12, complained of difficulty of breathing. This morning suffering from great dyspnoea; nares dilated; lips livid; countenance dusky. Perspiration 68; pulse 120; carotids pulsating forcibly. Had muscular tremours affecting all the muscles of his right leg. Complained of pain all over, especially at the back of his neck and at the lower dorsal region. Wound on arm dressed; edges gaping and bluish-looking. Dyspnoea gradually increased, with great restlessness; screaming with the pain in his back, and died at 12.30 P. M.

Autopsy.—A tumour was found in front and at the sides of the coccyx. The growth presented the ordinary characters

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of lymphadenoma, consisting of a coarse retiform connective tissue, with small somewhat irregular cells in its meshes. It filled the ischio-rectal fossa, and caused protrusion of the anus and neighbouring skin; from the anus it extended to a point two and a half inches above, where it terminated in a well-defined border; above this the tissues were brawny and infiltrated by a similar growth. The tumour firmly embraced, but was loosely attached to, the rectum. Extending upwards into the abdomen from the tumour was a chain of enlarged glands. On cutting through the muscles lying on the left side of the spine, on a level with the sixth dorsal vertebra, a mass of new growth, about the size of two hazel-nuts, was found; also, on the same level, between the coverings of the cord and the spinal canal, was another mass of new growth. In the walls of the heart were two or three small masses, also spots of ecchymosis. No emboli. Left lung oedematous; right healthy; small extravasations in both. Kidneys anæmic; on the left side the straight tubes were in places filled with blood. Under the mucous lining of the bladder was one spot of extravasated blood about the size of a pea. Ecchymosis in both retine, and the anterior part of both hemispheres of brain. Suppuration in both tonsils.—*Lancet*, July 21, 1877.

MEDICAL NEWS.

ORIGINAL ARTICLE.

Death from Gunshot Wound after an interval of Fourteen Years. By R. S. KEELER, of Phoenixville, Pa.—The length of time intervening between the date of injury and the death of the patient, as well as the peculiar course taken by the ball, renders this case one of considerable interest.

I was called, on December 25, 1876, to see Mr. J. L. —, who stated that he had been wounded at South Mountain, on September 14, 1862, and that his wound had never healed, because the ball could not be found. Upon examination I found a wound in the abdomen,

upon a level with the anterior-superior spinous process of the ilium, and at a point midway between this process and the linea alba. The patient informed me that pus had never ceased to be discharged from this wound, and that he had also secured thirty-two sequestra of different sizes. Although he had been probed repeatedly by several surgeons, no traces of lead could ever be detected. When I first saw him, he was suffering from hectic, and complained of intense pain upon the inner side of the thigh and leg. I did not think operative interference advisable at that time; hence I endeavoured to improve his general condition by constitutional treatment. Despite every effort, however, he failed rapidly, and died on January 10, 1877. I made an autopsy on January 12, and found that the missile, entering at the point already indicated, on the right side, struck the crest of the ilium, which it shattered. It then passed downward and forward, finally lodging upon the ramus of the ischium in the obturator foramen. The crest of the ilium was much thickened, and extensively necrosed upon its inner surface. The ball, when found, was much corroded and distorted in shape, weighing but six drachms, though we were able to identify it as a round ball of an ounce and a half weight. It may also be stated that there was no evidence that the ball had ever been encysted.

DOMESTIC INTELLIGENCE.

Canada Medical Association.—The tenth annual meeting of this Association will be held in the city of Montreal, on Wednesday, September 12, 1877.

American Public Health Association.—The fifth annual meeting of this Association will be held at Chicago, on Tuesday, September 25, 1877.

Minnesota State Medical Society.—The ninth annual meeting of this Society was held at St. Paul, on the 18th and 20th of June, Dr. F. H. Milligan, of Wabasha, presiding. The following officers were

elected for the ensuing year: President, Dr. Otis Ayer, of Le Sueur; Vice-Presidents, Drs. C. P. Adams, of Hastings; A. C. Wedge, of Albert Lea; and E. E. Collins, of Minneapolis. Treasurer, Dr. S. B. Sheardown, of Winona; Secretary, Dr. C. H. Boardman, of St. Paul.

Illinois State Board of Health.—The people of Illinois are to be congratulated upon the enactment by their last Legislature of a bill to establish a State Board of Health. The Board has organized by the unanimous election of Dr. J. H. Rauch, of Chicago, as President and Acting Secretary—a selection which gives great promise of the future efficiency of the Board.

Bromide of Ammonium in Hay Fever.—Dr. E. C. SUGVIN, of New York, reports (*Journal of Nervous and Mental Diseases*, July, 1877) that last year he induced two or three persons suffering from this disease to employ a strong gargle of bromide of ammonium, and to wash out the nasal passages with a weak solution of the same salt several times a day during the attack. The result was so gratifying that he is disposed to ask physicians to give a fair trial to this treatment during the coming summer and autumn. The gargle to be of the strength of 3j or 3ij of bromide to 3j water; the solution for the nares much weaker, of from 10 to 80 grains of bromide in 3j water.

Honour to Physicians of Pittsburg.—During the recent severe experience of the Philadelphia militia at Pittsburg, whither they were sent by the Governor of the State to aid the constituted authorities in suppressing the railroad riots, and while the citizens of that place generally appeared to be inimical to the troops, the first of the few who promptly came forward with friendly offers of food and personal aid were members of the medical profession. We are gratified to be able to record this to their honour, upon information derived from an official source.

OBITUARY RECORD.—At Hanover, New Hampshire, on August 10th, ALPHEUS

BENNING CROSBY, M.D., aged forty-five years.

Dr. Crosby held the Professorship of Anatomy in Bellevue Hospital Medical College, and was a son of the late Dr. Dixi Crosby, of New Hampshire.

FOREIGN INTELLIGENCE.

Slow Pulse.—M. RENDU brought a labouring man, aged thirty-eight, before the Lyons Medical Society, as exhibiting a remarkably slow pulse, viz., 41 to 42 per minute, no difference being, however, notable whether he was in the erect, recumbent, or sitting posture. The man, who was robust and in perfect health, had applied for some trifling ailment. Not only is the case interesting on account of the slow pulse, but because it proves an exception to the rule laid down by Graves, that whenever there is no appreciable difference in the pulse in the different positions of the body, there is always hypertrophy of the heart accompanied by dilatation. Graves only met with six cases in which the difference was not observable, and in all these this lesion was present. However, in the present case there is no sign whatever of disease of the heart. — *Med. Times and Gaz.*, July 14, 1877, from *Lyon Méd.*, July 1.

Hay Fever.—A correspondent of the *Lancet* (July 21, 1877) says that an ointment of one grain of morphia, ten grains of quinia, and three drachms of spermaceti ointment, when smeared on the inside of the nostrils in small quantities, relieves the irritation consequent on hay fever.

Fetid Feet.—In an article in the *Revue de Thérapeutique* it is stated that an immediate remedy for this noisome affection is found in washing the feet with a solution (1 in 100) of chloral, and keeping them enveloped in compresses wetted with the same solution. Results as satisfactory have long since been obtained by Dr. Bourdon by the employment of a solution (commencing with 8 in 1000) of the permanganate of potash. Dr. Berthold also indicates an efficacious method which is

less troublesome than that of bathing with solutions. It consists in powdering the interior of the patient's socks with a powder composed of one part of salicylic acid and five of starch. This is, too, an excellent mode of treating the local sweating which in fat persons often takes place between the scrotum and the thighs, and if not arrested leads to a troublesome eczema, and its accompanying pruritus.—*Med. Times and Gaz.*, August 4, 1877.

Death from Milk in the Trachea.—At the Geneva Medical Society, Dr. ODIER related (*Lyon Méd.*, June 24) the case of a boy about four years of age, who, while taking some milk at table, sank his head and became suddenly pale, death taking place in two or three minutes without struggle or cyanosis. At the autopsy a small fragment of bread was found in the epiglottis, and at the bifurcation of the bronchi there was also found a little bread softened with milk, but which in no wise obstructed the bronchi. A little lower down in the bronchi there were also fragments of the same of the size of a pin's head. Death in this case must have taken place from syncope, and not from suffocation. The heart and lungs were quite healthy, and there were neither subpleural ecchymoses nor bronchial foam. Dr. D'Espine referred to the rapidity with which asphyxia occurs in children who have undergone tracheotomy on the escape of the canula, so that death is imminent unless this be instantly replaced. Dr. Juillard met with the case of an infant at the breast found dead in its cradle. Some coagulated milk was found in the trachea, but not in sufficient quantity to produce obstruction. Dr. Prévost believed the mechanism of death in these cases is similar to that produced in animals by stimulating the central end of the inferior laryngeal, which arrests the diaphragm and respiration. In these cases there may be a similar reflex action due to the foreign body conjoined with the spasmodic element.—*Med. Times and Gaz.*, June 30, 1877.

Death from Chloroform.—A death from chloroform occurred at the Toronto General Hospital on July 18. A woman, aged

twenty-five, was about to be operated upon for some uterine trouble, and but a few drops of the anæsthetic had been given when she suddenly died. She had taken chloroform previously and had no unpleasant symptoms. At the *post-mortem* fatty degeneration of the right ventricle was assigned as the cause of death.—*Canadian Journ. of Med. Sci.*, Aug. 1877.

The *British Med. Journ.* for August 4 reports the death from chloroform of Sarah Crudge, aged 23. The anæsthetic was administered for an operation for strabismus.

Colour-blindness among Railroad Employés.—An optical examination has been ordered by the Minister of Ways and Communications, at St. Petersburg, of all persons connected with Russian railways, in order that their power of distinguishing colours may be tested. It appears that this order has been issued in consequence of the startling results lately obtained from a similar examination of railway employés in Finland.—*Med. Examiner*, July 19, 1877.

We hope that railroad managers in this country will immediately profit by this experience and example.

Dr. Lewis A. Sayre in London.—We learn from the English journals that Dr. Sayre has been giving demonstrations at the London hospitals, of his mode of treating Pott's disease, and lateral curvature by suspension and fixation. The *Lancet* (July 14) says: "We are not blind to the fact that much of the success obtained is due to Dr. Sayre's own rare mechanical and manipulative skill, but his principles are as sound physiologically as their application is mechanically expert, and we thank him most heartily for the trouble he is taking in England to illustrate and enforce them."

Dr. Edward Warren.—Dr. Warren (Bey), of Paris, formerly of North Carolina, has just received the Cross of Chevalier of the Order of Isabel the Catholic, as a recognition of his professional services to Spanish personages.—*Lancet*, July 14.

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PART I. ANATOMY AND PHYSIOLOGY. SEC. I. EXTERNAL EAR. Chap. I. The Auricle. Chap. II. The Auditory Canal. Chap. III. Membrana Tympani. SEC. II. MIDDLE EAR. Chap. I. Tympanic Cavity. Chap. II. Eustachian Tube and Mastoid Portion. SEC. III. INTERNAL EAR. Chap. I. Labyrinth and Auditory Nerve. Chap. II. Scheme of Relationship between the Middle and Internal Ear.

PART II. DISEASES AND TREATMENT. SEC. I. EXAMINATION OF PATIENTS. Chap. I. Instruments, and Methods of their Employment. Chap. II. Sound, Hearing, and Tests of the Latter. SEC. II. AURICLE. Chap. I. Organic Defects and Cutaneous Diseases. Chap. II. Morbid Growths and Injuries. SEC. III. EXTERNAL AUDITORY CANAL. Chap. I. Circumscribed and Diffuse Inflammation. Chap. II. Foreign Bodies in the External Ear. Chap. III. Results of Inflammation and Injury. SEC. IV. MEMBRANA TYMPANI. Chap. I. Acute and Chronic Inflammation. Injuries and Morbid Growths. SEC. V. MIDDLE EAR. Chap. I. Acute Catarrhal Inflammation. Chap. II. Chronic Catarrhal Inflammation. Chap. III. Treatment of Chronic Catarrhal Inflammation. Chap. IV. Unusual Diseases of the Middle Ear. Chap. V. Acute Purulent Inflammation. Chap. VI. Chronic Purulent Inflammation. Chap. VII. Course and Consequences of Chronic Purulent Inflammation of the Middle Ear. Chap. VIII. The same, continued. SEC. VI. DISEASES OF THE INTERNAL EAR. Chap. I. Primary and Secondary Inflammation. Chap. II. Morbid Growths of the Auditory Nerve. SEC. VII. DEAF MUTES AND PARTIALLY DEAF CHILDREN. Chap. I. Diagnosis and Treatment of Deaf-mutism and Partial Deafness in Children.

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